MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 79 — 01499

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Keymar
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? lifetime

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Keymar
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Kenneth Franklin Abra

3. (b) Social Security Number: 212-24-6381

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 1, 1927

8. AGE: Years	Months	Days	If less than one day
20	10	23	..... hrs. ..... min.

9. Birthplace: Keymar, Carroll Co., Maryland
(Town, county, and state)

10. Usual occupation: laborer

11. Industry or business

FATHER — 12. Name: William Abra

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Clara Otto

MOTHER — 15. Birthplace: Maryland

16. Informant: Mr. William Abra

Address: Keymar, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 27 1948 (month) (day) (year)

Cemetery or crematory: St. Joseph's Cemetery

Location: Taneytown, Maryland

18. Funeral director: C.O. Fuss & Son

Address: Taneytown, Maryland.

19 Feb-25 1948 (Date rec'd by registrar) Barney M. T. Powell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 24 1948, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 31 1948, to Feb 24 1948 and that I last saw him alive on Feb 24 1948

Immediate cause of death	DURATION
Pneumonia	
Due to Pulmonary Tuberculosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: J. H. Legg M. D. or other

Address: Union Bridge Date signed 2-26-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01500

94a

CERTIFICATE OF DEATH

Reg. Diat. No. H-78

1. PLACE OF DEATH:
County: Carroll
City or town: Near Taylorsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Near Taylorsville Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Mary B Albert

3. (b) Social Security Number 210-20-3961

4. Sex: Femal
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Married
6. (b) Name of husband or wife: Walter J Albert
6. (c) If alive, give age: 47 years
7. Birth date of deceased (mo., day, yr.): May 22 1899
8. AGE: Years: 48 Months: 8 Days: 9 If less than one day: hrs. min.
9. Birthplace: Manchester Carroll Co. (Town, county, and state)
10. Usual occupation: House Wife
11. Industry or business
FATHER 12. Name: Charles N. Yingling
13. Birthplace: Manchester Md
MOTHER 14. Maiden name: Hassie Zimmerman
15. Birthplace: Manchester Md
16. Informant: Mrs. Robert Stonesifer
Address: Westminster Md R.D. #1
17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 4 48 (month) (day) (year)
Cemetery or crematory: cemetery
Location: Manchester Md
18. Funeral director: Jacob Unger Sons
Address: Manchester Md
19. 2/3 48 K F (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 1 1948 at 2:30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1, 1940 to Feb 1, 1948 and that I last saw her alive on Jan 31, 1948
Immediate cause of death: Coronary occlusion — DURATION: 30 hrs
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C Reese Wilkens M.D.
M. D. or other
Address: Westminster Date signed 2/1/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

01501

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

Reg. Diat. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Carroll

City or town Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs. 7 mos 20 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 4 yrs., 7 mos., 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Unknown
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Sadie Lucille Allnutt

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 20, 1891

8. AGE: Years	Months	Days	If less than one day
56	8	25	hrs. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business

FATHER 12. Name Joseph Allnutt

FATHER 13. Birthplace U.S.A.

MOTHER 14. Maiden name Lucie Williams

MOTHER 15. Birthplace U.S.A.

16. Informant Hospital Records

Address Springfield Sta te Hospital

17. Removal to (Burial, cremation, or removal. Which?) Date thereof 2-14-48 (month) (day) (year)

Cemetery or crematory Baltimore, Md.

Location

18. Funeral director Wm. Reuben Sanders

Address 7557 Wis Ave. Bethesda Md.

19. Feb. 15 1948 Harry Kerr
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 14 1948, at 1:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 25, 1943, to February 14, 1948 and that I last saw her alive on February 14 1948

Immediate cause of death	DURATION
Chronic Myocarditis with	5 weeks
Myocardial Degeneration	
Due to Asthma	
Due to	
Other conditions Involutional Melancholia	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Virginia Beyer M.D. M. D. or other

Address Springfield State Hospital Date signed 2-14-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01502

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 month 21 days

Hospital, Institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium

How long in hospital or Institution? Colored Branch, Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 505 Myrtle Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Ella Austin

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	Colored	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 17, 1943

8. AGE:

Years	Months	Days	If less than one day
4	5	16	hrs. min.

9. Birthplace: Baltimore, Maryland

(Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER

12. Name: Henry Austin

13. Birthplace: Unkown

MOTHER

14. Maiden name: Helen Walls

15. Birthplace: Unknown

16. Informant: Grandmother- Mrs. Ella Allen

Address: 678 N. Mulberry St. Baltimore

Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 4 1948 (month) (day) (year)

Cemetery or crematory:

Location:

18. Funeral director: Robertson Hall

Address: 618 Druid Hill Ave

19. Feb 2 1948 (Date rec'd by registrar) Albert R. Swanhart Registrar

Local Deputy

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 2 1948 at 8:40 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 12 1947 to February 2 1948 and that I last saw her alive on February 2 1948

Immediate cause of death: Pulmonary Tuberculosis — DURATION: August 1946

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Reuben W. Swan, M.D. M. D. or other

Address: Henryton, Maryland Date signed: 2/2/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect or incomplete answer is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01503

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 yrs. 10mos. 8 days
Hospital, Institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 14 yrs. 10 mos. 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 43 North Eden Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: SOPHIA BARD

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	S

6.(b) Name of husband or wife:
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): 12/24/01

8. AGE: Years	Months	Days	If less than one day
46	1	11	hrs. min.

9. Birthplace: Russia (Town, county, and state)
10. Usual occupation: None
11. Industry or business

FATHER
12. Name: Reuben Bard
13. Birthplace: Russia

MOTHER
14. Maiden name: Fannie Rothenberg
15. Birthplace: Russia

16. Informant: Record, Springfield State Hospital
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-6-48 (month) (day) (year)
Cemetery or crematory: Hebrew Herzeeg Reem
Location:
18. Funeral director: Jack Lewis, Inc
Address: 400 Eutaw Place

19. Feb 6 1948 (Date rec'd by registrar) C. Harry Lukes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 5 1948 at 9:25 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 16 1948 to February 5 1948 and that I last saw h. 34 alive on February 5 1948

	DURATION
Immediate cause of death: Metastatic carcinoma of liver	
Due to: Primary carcinoma of left breast (mastectomy, April 1946)	2 yr.
Due to:	
Other conditions: Psychosis with epilepsy	36 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Joseph H. Marshall, M.D. M. D. or other
Address: Sykesville, Maryland Date signed: 2/5/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01504

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 day
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or institution? Colored Branch

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore, 5
(If outside city or town limits, write RURAL and give nearest town)
Street No. 709 Spring Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: BUD BOOKER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widowed

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): ? ? 1888 ?

8. AGE: Years: 59 ? Months: ? Days: ? If less than one day: hrs. min.

9. Birthplace: Cumberland, Maryland (town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER
12. Name: William Booker
13. Birthplace: Unknown

MOTHER
14. Maiden name: Fannie Booker
15. Birthplace: Unknown

16. Informant: Deceased
Address:

17. (Burial, cremation, or removal. Which?) Burial Date thereof: (month) (day) (year)
Cemetery or crematory: Mt. Calvary
Location: Anne Arundel Co. Md.

18. Funeral director: Elroy A. Wilson
Address: 1000 Belvedere Ave

19. Feb. 1, 1948 (Date rec'd by registrar) Albert R. Shreckhise Local Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 1, 1948, at 12:30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 30 1948 to Feb. 1 1948 and that I last saw him alive on February 1, 1948

Immediate cause of death — DURATION

Pulmonary Tuberculosis — Jan. 1946

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Mulleen Hoffman, M.D. M. D. or other
Address: Henryton, Maryland Date signed: 2-1-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate if information is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS/A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01505

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Maryland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 month 25 days
Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium
How long in hospital or institution? Colored Branch, Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No. 837 Ostend Street (If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Mary Elizabeth Brown

3.(b) Social Security Number: 216-16-0823

4. Sex: female
5. Color or race: col
6.(a) Single, married, widowed, or divorced: Separated
6.(b) Name of husband or wife: Solomon Brown
6.(c) If alive, give age: 29 years
7. Birth date of deceased (mo., day, yr.): September 30, 1923
8. AGE: Years: 24 Months: 4 Days: 3 If less than one day: ....hrs. ....min.
9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: Waitress
11. Industry or business:

FATHER
12. Name: William Hall
13. Birthplace: Anne Arundel Co. Maryland

MOTHER
14. Maiden name: Beaulah Gatney
15. Birthplace: Portsmouth, Virginia

16. Informant: Deceased
Address:

17. (Burial, cremation, or removal. Which?) Burial Date thereof: 2 5 48 (month) (day) (year)
Cemetery or crematory: Mt. Calay Cemty.
Location: Balto. Md.
18. Funeral director: Walter B. Pugh
Address: 139 W. Lanvale St.

19. Feb. 2 19 48 (Date rec'd by registrar) Local Deputy Registrar

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH: February 2 19 48 at 4:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 8 19 47 to Feb. 2 19 48 and that I last saw h...er alive on February 2 19 48

Immediate cause of death	DURATION
Pulmonary Tuberculosis	1943
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Nathan W. Bonar, M.D. M. D. or other
Address: Henryton, Maryland Date signed: 2/2/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01506

93d

Reg. Dist. No. 76

1. PLACE OF DEATH:
County: Carroll
City or town: Finksburg
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Finksburg Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: BENJAMIN ALDRET CALDER

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife: None
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 6, 1896

8. AGE: Years	Months	Days	If less than one day
52	1	9	hrs. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: Edward E. Calder
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden name: Alice E. Aldret
15. Birthplace: Charleston, S. Car.

16. Informant: Alice Calder
Address: 404 E. Lake Avenue

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 18, 1948 (month) (day) (year)
Cemetery or crematory: Greenmount
Location: Baltimore, Maryland

18. Funeral director: William Cook, Inc.
Address: 1217 St. Paul Street

19. 2/16/48 (Date rec'd by registrar) A W Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 15 1948, at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 20 1947, to Feb. 15 1948, and that I last saw h[illegible] alive on Feb. 15 1948

Immediate cause of death	DURATION
Myocardial degeneration	14 mos. ±
Due to	
Due to	
Other conditions: Old Potts disease	50 yrs

(Include pregnancy within 3 months of death)

Major findings:
01 operations: —
01 autopsy: —

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: E Reese Wilkens M. D. or other
Address: Westminster Date signed: 2/15/48

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

932 015417

Reg. Diat. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No. 7 Park Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Laura B. Caple

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widow

6.(b) Name of husband or wife: Vinton P. Caple

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 21, 1890

8. AGE: Years	Months	Days	If less than one day
57	11	2	hrs. min.

9. Birthplace: Carroll County, Md. (Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER 12. Name: Jeremiah W. Robertson

13. Birthplace: Maryland

MOTHER 14. Maiden name: Clara B. Poole

15. Birthplace: Maryland

16. Informant: Stanley Caple

Address: Westminster, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 2/26/48 (month) (day) (year)

Cemetery or crematory: Sandymount Cemetery

Location: Sandymount., Md.

18. Funeral director: J. Francis Reese

Address: Westminster, Md.

19. 2/24/48 (Date rec'd by registrar) 1948 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 23 1948 at 9¾p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 1 1948, to February 23 1948 and that I last saw h[illegible] alive on February 23 1948

Immediate cause of death	DURATION
Coronary Occlusion	Feb 23
Due to Coronary Sclerosis & angina	7 yrs
Due to Arteriosclerosis general myocardial degeneration	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. Glenn Beecher M. D. or other

Address Westminster, Md. Date signed 2/24/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

BC 13b

01508

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 days

Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch, Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 213 N. Wolfe Street
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Frank Edward Chase

3.(b) Social Security Number: 218-07-5950

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col	Married

6.(b) Name of husband or wife: Helen Chase

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 20, 1904

8. AGE: Years	Months	Days	If less than one day
43	2	22	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Shipping Clerk

11. Industry or business:

FATHER
12. Name: Frank Chase
13. Birthplace: Grayson, Maryland

MOTHER
14. Maiden name: Emma Taylor
15. Birthplace: Grayson, Maryland

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/15/48 (month) (day) (year)

Cemetery or crematory: Mt. Calvary Cem.

Location: A. A. County, Md.

18. Funeral director: Joseph G. Lorki, D.

Address: 1304 N. Central Ave

19. Feb. 11 1948 (Date rec'd by registrar) Albert R. Swandner Registrar
Local Deputy

MEDICAL CERTIFICATION A.

20. DATE OF DEATH: February 11 1948 at 4:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 19 1948, to Feb. 11 1948 and that I last saw h... im alive on February 11 1948

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Nov. 20 1939

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Reuben W. Foman M.D.
M. D. or other

Address: Henryton, Maryland Date signed: 2/11/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

01542

CERTIFICATE OF DEATH

Reg. Dist. No. 7

1. PLACE OF DEATH:

County: Carroll

City or town: Greenmount

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Greenmount

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John E Elas

3.(b) Social Security Number 189-07-1253

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M.

6.(b) Name of ~~husband~~ or wife: Ada S Elas

6.(c) If alive, give age: 68 years

7. Birth date of deceased (mo., day, yr.): Dec 26 - 1877

8. AGE: Years: 70 | Months: 1 | Days: 19 | If less than one day: ...hrs. ...min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Plumbing

FATHER — 12. Name: Charles Elas

FATHER — 13. Birthplace: Germany

MOTHER — 14. Maiden name: Maggie Theirit

MOTHER — 15. Birthplace: Germany

16. Informant: Mrs John Elas

Address: Greenmount Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 18 48 (month) (day) (year)

Cemetery or crematory: Greenmount

Location: Carroll Co. Md

18. Funeral director: Edw A Tipton

Address: Hampstead Md

19. Feb 17 19 48 (Date rec'd by registrar) John S. Hughes Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 15 1948 10 45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 1947 to Feb. 15 1948

and that I last saw him alive on Feb. 14 1948

Immediate cause of death	DURATION
Cerebral Thrombosis	3 wks
Due to: Cerebral arteriosclerosis	1 year
Due to:	
Other conditions: Arterio-Sclerotic Heart disease	6 years

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: Maurice C. Porterfield M. D. or other

Address: Hampstead, Md. Date signed: 2-16-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01510

Reg. Diat. No. 76

1. PLACE OF DEATH:

County: Carroll

City or town: Rural near Westminster Rfd.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? All his life

Hospital, Institution, or street address where death occurred: (Charles Street)

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Rural near Westminster
(If outside city or town limits, write RURAL and give nearest town)

Street No. (Charles St.)
(If rural, give LOCATION)

2.(a) If veteran, name war: World War I

3.(a) FULL NAME: James Washington Edward Cross

3.(b) Social Security Number: 214-01-0672

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Colored	Married

6.(b) Name of husband or wife: Mabel B. Cross

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Jan. 25 1896

8. AGE: Years: 52 Months: 00 Days: 22 If less than one day: ____ hrs. ____ min.

9. Birthplace: Westminster Carroll Co. Md.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER
12. Name: Luther C. Cross
13. Birthplace: Westminster Md.

MOTHER
14. Maiden name: Ella May Cross
15. Birthplace: Carroll Co. Md.

16. Informant: Mrs. Ella M. Cross

Address: Charles St. Westminster Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 21 48 (month) (day) (year)

Cemetery or crematory: Western Chapel Cem.

Location: Rural near Westminster Md.

18. Funeral director: J. E. Myers Jr.

Address: Westminster Md.

19. Feb 19 1948 (Date rec'd by registrar) J. L. Cunningham Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb - 17 - 1948, at 8.10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept - 1947, to Feb 17 - 1948 and that I last saw h... alive on Feb 16 - 1948

Immediate cause of death	DURATION
Myocarditis (chr)	
Nephritis (chr) Arteriosclerosis (Uremia)	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: None Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: W. C. Jamuta M.D.
M. D. or other

Address: Westminster Md. Date signed: 2-18-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS/A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01511

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 26 yr. 2 mths. 5 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 26 yr. 2 mths. 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: GARNET L. DAWSON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: George H. Dawson
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 12, 1894

8. AGE: Years	Months	Days	If less than one day
53	10	13	..... hrs. ..... min.

9. Birthplace: St. Mary's County, Maryland (Town, county, and state)
10. Usual occupation: Housewife prior to admission
11. Industry or business

FATHER
12. Name: William Hilton
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary Rutter
15. Birthplace: Maryland

16. Informant: Hospital records
Address: Springfield State Hospital Sykesville, Maryland

17. (Burial, cremation, or removal. Which?) Date thereof: Feb. 27-48 (month) (day) (year)
Cemetery or crematory: St Thomas
Location: Balto Co.
18. Funeral director: J. F. Eline Sons
Address: Reisterstown, Md.

19. Feb 25 1948 (Date rec'd by registrar) C. Stacy Keer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2/25 1948 at 11:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/13 1948 to 2/25 1948 and that I last saw her alive on 2/24/48 1948

Immediate cause of death	DURATION
Chronic Myocarditis and Myocardial Degeneration	More than 2 years.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: Dilated Rt. Ventricle. Chronic Passive Congestion Liver Spleen
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Morton Jacobs M.D.
Address: Springfield State Hosp. M. D. or other
Date signed: 2/25/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

61 01512

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 days
Hospital, Institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Cockeysville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Isabel S. Dorsett

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: Samuel H. Dorsett
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan 13th 1874

8. AGE: Years	Months	Days	If less than one day
74	1	7	..... hrs. ..... min.

9. Birthplace: St. Louis, Missouri
(Town, county, and state)
10. Usual occupation: None
11. Industry or business

FATHER
12. Name: George Southall
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden name: Fanny Cunningham
15. Birthplace: Baltimore, Maryland

16. Informant: Springfield State Hospital records
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/24/48 (month) (day) (year)
Cemetery or crematory: Woodlawn
Location: Balto. Co. Md.
18. Funeral director: William Cook Inc
Address: 1217 St. Paul st

19. Feb. 20 1948 (Date rec'd by registrar) Nancy Hess Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 20, 1948 at 6:45 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 14, 1948 to Feb. 20, 1948 and that I last saw her alive on February 20, 1948

Immediate cause of death	DURATION
Hypertensive cardiovascular disease	?
Generalized arteriosclerosis	?
Due to Diabetes mellitus	?
Psychosis with cerebral	
Due to arteriosclerosis	7 mos.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Joseph H. Marshall, M.D.
Springfield State Hospital M. D. or other
Address: Sykesville, Maryland Date signed 2/20/48

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01513

Reg. Dist. No. 81

1. PLACE OF DEATH:

County: Carroll

City or town: Union Bridge
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Union Bridge
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Martha Matilda Dudrear

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: Charles E Dudrear

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan 14 - 1873

8. AGE:

Years	Months	Days	If less than one day
75	1	12	hrs. min.

9. Birthplace: Frederick County, Maryland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: James Bastian
13. Birthplace: Maryland

MOTHER
14. Maiden name: Sarah Fogle
15. Birthplace: Maryland

16. Informant: Mrs. Ruth Shiffler

Address: Union Bridge, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 29 - 1948 (month) (day) (year)

Cemetery or crematory: Fairmount Cemetery

Location: Liberty town

18. Funeral director: D. D. Hartzler & Sons

Address: Union Bridge & New Windsor, Md.

19. Feb 28, 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 26 1948, at 11:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1948 to Feb 26 1948

and that I last saw h... alive on Feb. 26 1948

Immediate cause of death: Cerebral Hemorrhage

DURATION

Due to:

Due to:

Other conditions: Diabetes

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. H. Mason M.D. M. D. or Coroner

Address: Union Bridge Date signed: Feb 28

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

01514

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 21 days

Hospital, Institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Frederick

City or town: Braddock Heights
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: none

3.(a) FULL NAME

WALTER EADER

3.(b) Social Security Number

none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	WIDOWED

6.(b) Name of husband or wife: ?

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): ? 1878

8. AGE: Years	Months	Days	If less than one day
70			..... hrs. ..... min.

9. Birthplace: Frederick County
(Town, county, and state)

10. Usual occupation: Tailor

11. Industry or business

FATHER
12. Name: Peter Mantz Eader
13. Birthplace: Frederick County

MOTHER
14. Maiden name: Sidney Ann Bruchey
15. Birthplace: Frederick County

16. Informant: Record, Springfield State Hospital
Address: Sykesville, Maryland

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof 2-27-48 (month) (day) (year)
Cemetery or crematory: Mt. Olivet Cemetery
Location: Frederick - Md.

18. Funeral director: C. E. Cline & Son
Address: Frederick - Md.

19. Feb. 25 1948 Harry Keer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 25 1948, 10:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 4 1948, to February 25 1948, and that I last saw h... im alive on February 25 1948.

	DURATION
Immediate cause of death: Chronic myocarditis	2
Due to: Hypertensive cardiovascular disease	2
Due to: Generalized arteriosclerosis	2
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: Joseph H. Marshall, M.D.
M. D. or other

Address: Sykesville, Maryland Date signed: 2/25/48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

01515

Reg. Dist. No. 74

M

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 31 yrs. 2 mos. 3 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 31 yrs. 2 mos. 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME
CARRIE GERTRUDE EVELY

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	S

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 3/4/1876

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
71	11	22		

9. Birthplace: Montgomery County, Maryland
(Town, county, and state)
10. Usual occupation: Housework
11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace:

MOTHER
14. Maiden name: Eliza Evely
15. Birthplace: Howard County, Maryland

16. Informant: Records, Springfield State Hospital
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 28 1948 (month) (day) (year)
Cemetery or crematory: Sykesville Md
Location: Montgomery Co. Md
18. Funeral director: Roy W. Barber
Address: Laytonsville Md.

19. Feb 26 1948 (Date rec'd by registrar) Harvey Steer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 26 19 48 at 6:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to February 26 48
and that I last saw h... er alive on February 25 19 48

Immediate cause of death: Chronic myocarditis — DURATION: 2 yrs.
Due to: Coronary thrombosis — 1 yr.
Due to: Generalized arteriosclerosis — 10 yrs.
Due to:
Other conditions: Schizophrenia, paranoid type — 32 yrs.
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Joseph N. Marshall M.D.
M. D. or other
Address: Sykesville, Maryland Date signed: 2/26/48

2182

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 931

CERTIFICATE OF DEATH

Reg. Dist. No. 81

M

1. PLACE OF DEATH:
County Carroll
City or town Union Bridge
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Union Bridge
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME George F. Eyler

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	Married

6.(b) Name of husband or wife Margaret C. Eyler
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 23-1867

8. AGE:

Years	Months	Days	If less than one day
80	10	27	hrs. min.

9. Birthplace Frederick County, Md.
(Town, county, and state)
10. Usual occupation Auctioneer
11. Industry or business Retired

FATHER
12. Name Henry Eyler
13. Birthplace Maryland

MOTHER
14. Maiden name Mary Engle
15. Birthplace Maryland

16. Informant Margaret C. Eyler
Address Union Bridge Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 22-1948 (month) (day) (year)
Cemetery or crematory Lutheran Cemetery
Location Keysville Md

18. Funeral director H. H. Hartley & Sons
Address Union Bridge Md

19. Feb 21 1948 A. Eichman Deputy Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 19 1948 at 4:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 14 1948 to Feb 19 1948 and that I last saw h. living alive on Feb 19 1948

Immediate cause of death	DURATION
Chronic myocarditis	
Due to Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. N. Legg M. D. or other
Address Union Bridge Date signed 2-19-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01516

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 27 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or institution? Colored Branch, Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1003 Pennsylvania Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Jessie James Faulkner

3. (b) Social Security Number: 241-03-0431

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col	Married

6.(b) Name of husband or wife: Teddy Faulkner
6.(c) If alive, give age: 29 years

7. Birth date of deceased (mo., day, yr.): March 29, 1909

8. AGE: Years	Months	Days	If less than one day
38	10	24	hrs. min.

9. Birthplace: Halifax, Virginia (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business

FATHER
12. Name: Willie G. Faulkner
13. Birthplace: Halifax Co. Virginia

MOTHER
14. Maiden name: Mary Woods
15. Birthplace: Halifax Co. Virginia

16. Informant: Deceased
Address: 1003 Penn. Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-24-48 (month) (day) (year)
Cemetery or crematory: M. F. Coleman Cemetery
Location: Cedar Hill Ext.
18. Funeral director: Adelaide Halstead
Address: 918 Druid Hill Ave.

19. Feb. 22 48 (Date rec'd by registrar) Local Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 22 19 48 at 1:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 26 19 48 to Feb. 22 19 48 and that I last saw him alive on February 22 19 48

Immediate cause of death	DURATION
Pulmonary Tuberculosis	June 1947
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben W. Foran, M. D. M. D. or other
Address: Henryton, Maryland Date signed: 2/22/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01517

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 month 5 days

Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 123 Amity Street
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Joseph Ford

3.(b) Social Security Number: 217-01-9531

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col	Widowed

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 27, 1880

8. AGE: Years	Months	Days	If less than one day
67	7	14	hrs. min.

9. Birthplace: Baltimore County, Maryland
(Town, county, or state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER
12. Name: Roy Ford
13. Birthplace: N. Carolina

MOTHER
14. Maiden name: Frances Hardy
15. Birthplace: Catonsville, Maryland

16. Informant: Deceased
Address:

17. (Burial, cremation, or removal. Which?) Burial Date thereof 2-14-48 (month) (day) (year)

Cemetery or crematory: Mt Auburn

Location: Balto. Md.

18. Funeral director: Charles L. Corbin

Address: 512 N. Carrollton Ave.

19. Feb. 10 1948 (Date rec'd by registrar) Albert M. Sandbank Local Deputy Registrar

MEDICAL CERTIFICATION A.

20. DATE OF DEATH: February 10 1948, at 4:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 5 1947 to February 10 1948 and that I last saw him alive on February 10 1948

Immediate cause of death	DURATION
Pulmonary Tuberculosis	May 1947
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Reuben Hyman, M.D.
M. D. or other

Address: Henryton, Maryland Date signed: 2/10/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

01518

CERTIFICATE OF DEATH

Reg. Diat. No. 16

1. PLACE OF DEATH:

County Carroll

City or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 45 yrs.

Hospital, Institution, or street address where death occurred:

153 E. Green

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No. 153 E. Green

(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME Ella May Forrest

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 4 - 1866

8. AGE:

Years	Months	Days	If less than one day
81	2	11	..... hrs. ..... min.

9. Birthplace Carroll Co. Md.

(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER

12. Name Isaac C. Forrest

13. Birthplace Carroll Co. Md.

MOTHER

14. Maiden name Diana Albaugh

15. Birthplace Carroll Co. Md.

16. Informant Mrs Etta Young

Address 176 W. Main, Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 17, 1948 (month) (day) (year)

Cemetery or crematory Pipe Creek Methodist

Location Wakefield, Carroll Co. Md.

18. Funeral director H. Bankard & Son

Address Westminster, Md.

19. 2/16 1948 [illegible] Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-15 1948, at 11.40 AM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from about Jan. 15 1946, to 2-15 1948 and that I last saw h-er alive on 2-13 1948

Immediate cause of death	DURATION
Cardio-vascular disease with hypertension	10 years
Due to	
Due to	
Other conditions Cerebral hemorrhage	several months

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE N. Billingslea M.D. M. D. or other

Address Westminster Md. Date signed 2-16-1948

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01519

108

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:
County: Carroll
City or town: Rural Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 49 years.
Hospital, institution, or street address where death occurred:
R.D. 4.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Rural Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R.D. 4
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Jane Foster

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6.(b) Name of husband or wife: Henry Foster
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 20 - 1855

8. AGE:	Years	Months	Days	If less than one day
	93	—	6	hrs. min.

9. Birthplace: England
(Town, county, and state)
10. Usual occupation: None
11. Industry or business
FATHER 12. Name: Not known
13. Birthplace: " "
MOTHER 14. Maiden name: Not known
15. Birthplace: " "
16. Informant: Mrs Adam Foster
Address: Westminster RD 4. Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 29 - 1948 (month) (day) (year)
Cemetery or crematory: Lutheran Cemetery
Location: Westminster, Md.
18. Funeral director: H Bankard & Son
Address: Westminster, Md.
19. 2 27 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 26 1948 at 8:45A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1947 to February 26 1948 and that I last saw her alive on Feb 26 1948

Immediate cause of death	DURATION
Pneumonia	2/18/48
Lobar	
Due to: Senility	
Due to:	
Other conditions: Ulceration Cystitis	6 mo

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: W Glenn Speicher M. D. or other
Address: Westminster Md. Date signed: 2/27/48

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01520

107

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Line out incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Carroll

City or town Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs. 2 mos. 27 days

Hospital, Institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 2 yrs. 2 mos. 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Frederick

City or town Frederick
(If outside city or town limits, write RURAL and give nearest town)

Street No. 247 Washington Street, Fred'k., Md.
(If rural, give LOCATION)

2.(a) If veteran, name war - - -

3. (a) FULL NAME

Thomas GOODMAN George Thomas Goodman

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife - - -

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) ~~unknown~~ Aug. 4, 1879

8. AGE Years	Months	Days	If less than one day hrs.	min.
~~xx~~ ? ~~xxxxx~~68	6	15		

9. Birthplace ? Frederick, Md.
(Town, county, and state)

10. Usual occupation laborer

11. Industry or business - - -

FATHER 12. Name ? George T. Goodman

13. Birthplace ? Frederick, Md.

MOTHER 14. Maiden name ? Sarah K. Hoffman

15. Birthplace ? Frederick Co. Md.

16. Informant Records of the Springfield State Hospital
Address

17. Burial Date thereof Feb. 21 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. Olivet

Location Frederick, Md.

18. Funeral director M. R. Etchison & Son

Address Frederick, Md.

19. Feb. 20 1948 Harry Keer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 19 1948 at 1:45 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1 1947, to Feb. 18 1948 and that I last saw him alive on February 18 1948

Immediate cause of death	DURATION
Bronchopneumonia	2 days
Due to - - -	
Due to	
Other conditions Psychosis with arteriosclerosis	7 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Martin Gross, M. D.
Martin Gross, M. D. M. D. or other

Address Sykesville, Maryland Date signed 2/19/48

RECEIVED
FEB 24 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01521

Reg. Dist. No. 74

1. PLACE OF DEATH.
County Carroll
City or town Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 mon., 23 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or institution? Colored Branch

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1441 E. Eager Street
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME
GLENDORA GRIFFIN

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 24, 1926

8. AGE:

Years	Months	Days	If less than one day
21	7	18	..... hrs. ..... min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER
12. Name Leroy Dixon
13. Birthplace Unknown

MOTHER
14. Maiden name Marie Griffin
15. Birthplace Maryland

16. Informant Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/16/48 (month) (day) (year)
Cemetery or crematory Mt. Calvary
Location Brooklyn Md
18. Funeral director Elroy Dickson
Address 2000 Bryant Lane.

19. Feb. 12 (Date rec'd by registrar) 48 Albert R. Grandstaff Local Deputy Registrar

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH February 12, 19 48 at 11:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 19, 19 47 to Feb. 12, 19 48
and that I last saw her alive on February 12, 19 48

Immediate cause of death Pulmonary Tuberculosis — DURATION July 1947

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Reuben W. Foman, M.D.
M. D. or other
Address Henryton, Md. Date signed 2-12-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01522

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 yrs. 9 mos. 16 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 18 yrs. 9 mos. 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.:
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME
MAYNARD GUTRIDGE

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	SINGLE

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 30, 1908.

8. AGE: Years	Months	Days	If less than one day
39	5	28	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Huckster

11. Industry or business

FATHER — 12. Name: Henry Gutridge

13. Birthplace: Virginia

MOTHER — 14. Maiden name: Annie Hochstein

15. Birthplace: Maryland

16. Informant: Hospital records

Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Mar. 1 1948 (month) (day) (year)

Cemetery or crematory: Baltimore Md.

Location

18. Funeral director: J. B. Hippert & Son

Address: Eutaw Place & Lanvale St.

19. Feb 27 1948 (Date rec'd by registrar) Harry Heer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 27 1948 at 12:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..., to February 27 1948

and that I last saw him alive on February 27 1948

Immediate cause of death	DURATION
Pulmonary Tuberculosis	5 yrs.
Due to	
Due to	
Other conditions: Schizophrenia, hebephrenic type	23 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: Pulmonary tuberculosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Joseph H. Marshall, M.D. M. D. or other

Address: Springfield State Hospital Date signed: 2/27/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01523

83a

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs 2 da

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 2 yrs 2 da

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Washington

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3. (a) FULL NAME Minnie Elizabeth Staines

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Aug 20 - 1908

8. AGE: Years	Months	Days	If less than one day
39	6	3	____ hrs. ____ min.

9. Birthplace Md.

(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER

12. Name Barton H. Staines

13. Birthplace Allegany

MOTHER

14. Maiden name Sarah Beaver Staines

15. Birthplace Allegany

16. Informant Mrs. Thelma A. Hesselbacher

Address R.F.D. Harpers Ferry W Va

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 1 1948 (month) (day) (year)

Cemetery or crematory Springfield Hospital Cemetery

Location Sykesville Md.

18. Funeral director Harry Heer

Address Sykesville Md.

19. Mar. 1 1948 Harry Heer

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 23d 1948 at 7 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 20th 1946 to Feb 23 1948; and that I last saw h alive on ____ 19____

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to Essential Hypertension	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ____ Date of op. ____

Autopsy results ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE James T. Hamill Deputy Medical Examiner

M. D. or other

Address Westminster Md. Date signed 2-23-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83w

01521

Reg. Dist. No. 78

1. PLACE OF DEATH:

County Carroll

City or town Rural Taneytown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

Harney

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Taneytown Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Samuel D.Hawn

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife Mary E.Hawn

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Mar 2,1865

8. AGE: Years	Months	Days	If less than one day
82	11	18	..... hrs. ..... min.

9. Birthplace Md (Town, county, and state)

10. Usual occupation laborer

11. Industry or business

FATHER — 12. Name Josiah Hawn

13. Birthplace Md

MOTHER — 14. Maiden name Catherine Sowers

15. Birthplace Md.

16. Informant Mrs.Samuel D.Hawn

Address Taneytown,Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof Feb.23.1948. (month) (day) (year)

Cemetery or crematory Harney Lutheran

Location Harney,Md.

18. Funeral director C.O.FUSS & SON

Address Taneytown,Md.

19. Feb 22 1948 (Date rec'd by registrar) Ethel M Melzing Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 20 1948 at 5:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Cerebral hemorrhage	
Due to Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James T. Monk, Deputy Medical Examiner M. D. or other

Address Westminster Md Date signed 2-20-48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01525

Reg. Dist. No. 74

83a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Rural, Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr., 5 mo., 3 days

Hospital, Institution, or street address where death occurred:
Springfield State Hospital, Sykesville, Md.

How long in hospital or institution? 1 yr., 5 mo., 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Balto., city

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 2877 Chesterfield Ave
(If rural, give LOCATION)

2.(a) If veteran, name war: ----

3.(a) FULL NAME: HEATH, Richard, Ray

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Margaret E. Heath

6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): 12-26-74

8. AGE: Years	Months	Days	If less than one day
73	1	6	..... hrs. ..... min.

9. Birthplace: Baltimore City, Md.
(Town, county, and state)

10. Usual occupation: Barber

11. Industry or business: ----

FATHER
12. Name: Alfred Albert Heath
13. Birthplace: England

MOTHER
14. Maiden name: Alice Moffet
15. Birthplace: Frederick, Md.

16. Informant: Hospital records of Springfield
Address: State Hosp., Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-4-48 (month) (day) (year)
Cemetery or crematory: Mt Olivet Cem.
Location: Balto. Md.

18. Funeral director: William Cook Jr.
Address: 1217 St Paul St.

19. Feb. 1 1948 C. Harry Weaver
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 1, 1948 at 12,40A. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from September 1, 1947 to February 1, 1948 and that I last saw him alive on January 31, 1948

Immediate cause of death	DURATION
Cerebral hemorrhage	1 day
Due to	
Due to	
Other conditions: Psychosis with cerebral arteriosclerosis (Include pregnancy within 3 months of death)	about 6 yrs

Major findings of operations: ----
Date of op.

Autopsy results: Heart infarct., lung edema.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ---- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ----

Means of injury ---- Injured at work? ----

23. SIGNATURE: Martin Gross, M.D.
Martin Gross, M.D.
M. D. or other

Address: Sykesville, Md Date signed 2-1-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01526

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs. 5 month

Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 220 N. Amity St.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Nancy Hendricks

3.(b) Social Security Number: 219-10-3171

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col	Married

6.(b) Name of husband or wife: Aaron Hendricks

6.(c) If alive, give age: 33 years

7. Birth date of deceased (mo., day, yr.): July 4, 1924

8. AGE: Years	Months	Days	If less than one day
23	6	29	hrs. min.

8. Birthplace: Wilmington, N. Carolina
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: Edward Merrick

13. Birthplace: Willington, N. Carolina

MOTHER — 14. Maiden name: Goldie Millington

15. Birthplace: Willington, N. Carolina

16. Informant: Deceased

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 6. 1948 (month) (day) (year)

Cemetery or crematory: Mt Calvery Cem.

Location: Brooklyn Md

18. Funeral director: Clarys. Wilson

Address: 1000 Brantley ave

19. Feb. 2 (Date rec'd by registrar) 19 48 Albert R. Swanborn Local Deputy Registrar

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH: February 2 19 48 at 8:10 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 2 19 45 to Feb. 2 19 48 and that I last saw h er alive on February 2 19 48

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	June 1945
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M. D.
M. D. or other

Address: Henryton, Maryland Date signed: 2/2/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M


RECEIVED
FEB 5 1948
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 108

01527

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:
County Carroll
City or town Carrollton (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5-7 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Carrollton (Rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME John Hanak

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife Ada Hauble Hanak
6.(c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years	Months	Days	If less than one day
75	4	14	hrs. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual occupation Farmer
11. Industry or business

FATHER
12. Name John E Hanak
13. Birthplace Maryland

MOTHER
14. Maiden name Martha Miller
15. Birthplace Maryland

16. Informant Ada Hanak
Address Carrollton Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 13/48 (month) (day) (year)
Cemetery or crematory Bethel Church Cem
Location Carroll Co. Md
19. Funeral director Edward Tipton
Address Hampstead Md

19. 2/14 19 48 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 10 19 48 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 7 19 48 to Feb. 10 19 48
and that I last saw him alive on Feb. 10 19 48

Immediate cause of death	DURATION
Coronary Artery Disease	8 yrs
Due to	
Due to	
Other conditions Lobar Pneumonia	3 days
Vesico-Rectal fistula	8 weeks

(Include pregnancy within 3 months of death)

Major findings of operations Benign Prostatic Hypertrophy Date of op. Jan. 1948
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of Injury Injured at work?

23. SIGNATURE Maurice C. Porter M. D. or other
Address Hampstead, Md Date signed 2-11-48

VS-A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

01528

Reg. Diat. No. 87

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Carroll

City or town Union Bridge

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 mos.

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution? 5 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Union Bridge

(If outside city or town limits, write RURAL and give nearest town)

Street No. Elgin

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Cleon C. Jackson

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife Minnie C. Jackson

6.(c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) March 12 - 1869

8. AGE: Years	Months	Days	If less than one day
78	10	12	..... hrs. ..... min.

9. Birthplace Virginia (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name James B. Jackson

13. Birthplace Virginia

MOTHER 14. Maiden name Millie P. Jackson

15. Birthplace Virginia

16. Informant Clarence Jackson

Address Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 10. 1948 (month) (day) (year)

Cemetery or crematory Meadow Branch

Location Westminster, Md.

18. Funeral director H. Bankard & Son

Address Westminster, Md.

19. Feb. 8, 1948 (Date rec'd by registrar) Leslie D. Riefsnyder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 7 1948, at 9:15 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb 7 1948, to Feb 7 1948 and that I last saw him alive on Feb 7 1948

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. H. Legg M. D. or other

Address Union Bridge Date signed 2-7-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01529

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 month 30 days

Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch, Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1004 N. Bond St.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Freddie Johnson

3.(b) Social Security Number: 215-22-5397

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	dol	Married

6.(b) Name of husband or wife: Louise Johnson

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 1, 1918

8. AGE: Years	Months	Days	If less than one day
30	1	8	hrs. min.

9. Birthplace: Florence, N. Carolina
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER — 12. Name: Fred Johnson

13. Birthplace: S. Carolina

MOTHER — 14. Maiden name: Unknown

15. Birthplace: Unknown

16. Informant: Deceased

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/12/48 (month) (day) (year)

Cemetery or crematory: Mt Calvary

Location: Brooklyn, Md

18. Funeral director: Ehrot O. Wilson

Address: 1000 Brantly Lane

19. Feb. 9 19 48 (Date rec'd by registrar) Albert R. Trantham Local Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 9 19 48 at 2:15 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 10 19 47, to Feb. 9 19 48 and that I last saw him alive on February 9 19 48

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Oct. 1 1947
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Robert W. Inman, M. D.
M. D. or other

Address: Henryton, Maryland Date signed: 2/9/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

123

01530

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Rural Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs., 5 mo., 18 days.

Hospital, Institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 2 yrs., 5 mo., 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 301 South Bentlow Street

(If rural, give LOCATION)

2.(a) If veteran, name war: ----

3. (a) FULL NAME: JOHNSON, Guy

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife: ?

6.(c) If alive, give age: ---- years

7. Birth date of deceased (mo., day, yr.): 9-7-75

8. AGE: Years	Months	Days	If less than one day
72	5	15	....hrs. ....min.

9. Birthplace: Raliegh, N.C. (Town, county, and state)

10. Usual occupation: Actor

11. Industry or business: ----

FATHER

12. Name: ?

13. Birthplace: ?

MOTHER

14. Maiden name: ?

15. Birthplace: ?

16. Informant: Records of Springfield State Hosp.

Address: Sykesville, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 26 1948 (month) (day) (year)

Cemetery or crematory: Mt. Olivet

Location: Baltimore Md.

18. Funeral director: F. B. Kilpatrick & Son

Address: 1300 Eutaw Place, Baltimore

19. Feb 23 1948 (Date rec'd by registrar) Harry Keen Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 22 1948 at 2,18 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1 1948 to Febr. 22 1948 and that I last saw him alive on February 22 1948

Immediate cause of death	DURATION
Intestinal hemorrhage	6 hrs
Due to	
Due to	
Other conditions: Hypertension	?
Senile psychosis	3 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: ----

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ---- Date of ----

Where did injury occur? ---- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ----

Means of injury ---- Injured at work?

23. SIGNATURE: Martin Gross, M.D.

Martin Gross, M.D.

M. D. or other

Address: Sykesville, Md. Date signed 2-22-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01531

83a

Reg. Dist. No. 82

1. PLACE OF DEATH:

County: Carroll

City or town: near Mt. Airy, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town:

(If outside city or town limits, write RURAL and give nearest town)

Street No. R.D. Mt. Airy Md.

(If rural, give LOCATION)

2.(a) If veteran, name war: World War I.

3.(a) FULL NAME William P. Jones

3.(b) Social Security Number

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of ~~husband~~ or wife: Ervie Jones

6.(c) If alive, give age: 47 years

7. Birth date of deceased (mo., day, yr.): March 5, 1888

8. AGE: Years	Months	Days	If less than one day
59	1	7	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER — 12. Name: Robert Jones

13. Birthplace: Md.

MOTHER — 14. Maiden name: Mary Darsey

15. Birthplace: Md.

16. Informant: Mrs Ervie Jones

Address: Mt Airy Md

17. (Burial, cremation, or removal. Which?) Burial — Date thereof 2-15-1948 (month) (day) (year)

Cemetery or crematory: Mt. Zion

Location: near Mt. Airy Carroll Co Md

18. Funeral director: C. M. Wales

Address: Winfield, Md.

19. Feb 14 1948 (Date rec'd by registrar) M. R. Snyder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 12 1948 at 4'45 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb 12 1948 to Feb 12 1948 and that I last saw h~~im~~ alive on Feb 12 1948

Immediate cause of death	DURATION
Cerebral Hemorrhage	2-no.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE C. M. Van Fossen M. D. ~~Coroner~~

Address Mt Airy Md Date signed 2-14-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Evidence for change of age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01532

FILM No. G 114 MAR 11 1948 **CERTIFICATE OF DEATH**

Reg. Dist. No. 76

1. PLACE OF DEATH:

County Carroll

City or town Rural Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs

Hospital, institution, or street address where death occurred:

Annex C. Alms House

How long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Gamber

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME Albert Holten Jordan

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife Birtie Condon

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 27 - 1875

8. AGE: Years	Months	Days	If less than one day
73 ~~72~~	0	2	..... hrs. ..... min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name William H. Jordan

13. Birthplace Carroll Co. Md.

MOTHER 14. Maiden name Alice C. Williams

15. Birthplace Carroll Co. Md.

16. Informant John E. Jordan

Address Hampstead R.D.1. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 2 - 1948 (month) (day) (year)

Cemetery or crematory Mt. Pleasant Cemetery

Location Gamber, Md.

18. Funeral director H. Bankard Sons

Address Westminster, Md.

19. 3/1 1948 (Date rec'd by registrar) — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-29 1948, at 10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-10- 1948, to 2-29 1948 and that I last saw h... alive on 2-28- 1948

	DURATION
Immediate cause of death Lymphosarcoma of Pharynx.	1 yr
Due to Bad mouth condition	9
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations N.A. Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? N.A. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE N. C. Stone M. D. or other

Address Westminster Date signed 3/1/48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01533

Reg. Dist. No. 24

1. PLACE OF DEATH:
County: Carroll
City or town: Springfield State Hospital
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 mos.; 24 days
Hospital, Institution, or street address where death occurred: Springfield State Hospital
How long in hospital or institution? 5 mos., 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore City
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 213 S. Ann St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: James Kamasinski - Kamoza

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Separated

6.(b) Name of husband or wife: Frances Kaminska
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 2, 1911

8. AGE: Years	Months	Days	If less than one day
37	0	5	hrs. min.

9. Birthplace: Baltimore City, Md. (Town, county, and state)
10. Usual occupation: Bar-tender
11. Industry or business

FATHER
12. Name: John Kamasinski
13. Birthplace: Poland

MOTHER
14. Maiden name: Tilly Rychwalski
15. Birthplace: Poland

16. Informant: Hospital records
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 2-11-48 (month) (day) (year)
Cemetery or crematory: St. Stanislaus
Location: Baltimore Md.
18. Funeral director: George A Weber
Address: 705 South Ann st
19. 2/9/48 19 (Date rec'd by registrar) A. W. Hobbs Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 7, 1948 at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 14, 1947 to Feb. 7, 1948 and that I last saw him alive on Feb. 7, 1948

Immediate cause of death	DURATION
Pulmonary tuberculosis	7 mos (Approx)
Due to	
Due to	
Other conditions: Chronic Alcoholism	?

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Joseph H. Marshall, M.D. M. D. or other
Address: Springfield State Hospital Date signed: 2/7/48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

2183

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 939

CERTIFICATE OF DEATH

Reg. Dist. No. 81

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

1. PLACE OF DEATH:
County Carroll
City or town Union Bridge
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Union Bridge
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Annie Elizabeth Knipple

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widow

6.(b) Name of husband ~~or wife~~ Edward Knipple
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) 1850

8. AGE:

Years	Months	Days	If less than one day
98			..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER	12. Name William Fogle
	13. Birthplace Maryland
MOTHER	14. Maiden name Catherine Fogle
	15. Birthplace Maryland

16. Informant Mrs. Margaret C. Eyler
Address Union Bridge Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 22-1948 (month) (day) (year)
Cemetery or crematory Lutheran Cemetery
Location Keysville Md
18. Funeral director C. M. Hartsock & Sons
Address Union Bridge Md R. D. Westminster, Md
19. Feb 21 1948 (Date rec'd by registrar) Eichelberger County Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 20 1948, at 5:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 2 1948 to Feb 20 1948 and that I last saw h.e alive on Feb 19- 1948

Immediate cause of death	DURATION
Chronic Myocarditis	
Due to Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op.
Autopsy results.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE J. N. Legg M. D. or other
Address Union Bridge Date signed 2-21-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01534

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 23 years, 1 month, 15 days

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 23 years, 1 month, 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: unknown

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Clara Louisa Knoche

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 1864

8. AGE: Years	Months	Days	If less than one day
84	1	?	hrs. min.

9. Birthplace: Baltimore City (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business:

FATHER — 12. Name: Franz Knoche; 13. Birthplace: Germany

MOTHER — 14. Maiden name: Katherine ? unknown; 15. Birthplace: Germany

16. Informant: Hospital records

Address: Springfield State Hospital

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/6/48. (month) (day) (year)

Cemetery or crematory: Baltimore Cemetery

Location: 2 North Ave.

18. Funeral director: George Ruth Inc.

Address: 1735 Hanford Ave

19. 2/5 19 48 R.W. Hedrick DM (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: ~~January~~ February 4, 1948 at 12 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 2, 1942 to February 3, 1948 and that I last saw her alive on February 3, 1948

Immediate cause of death	DURATION
Chronic myocarditis and myocardial degeneration	about 2 years
Due to: hypertensive cardiovascular disease	about 9 years
Due to: generalized areteriosclerosis	about 15 years
Other conditions: Schizophrenia, hebephrenic type	30 years

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Irene H. Lehmann, M.D.

M. D. or other

Address: Springfield State Hospital Date signed: 2-4-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The dorm. age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

01535

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

122 l

CERTIFICATE OF DEATH

Reg. Dist. No. 79

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Carroll

City or town Keysville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? lifetime

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Keysville
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mrs Mary M Koontz

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widow

6.(b) Name of husband or wife O.R.Koontz

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec.31,1867

8. AGE:	Years	Months	Days	If less than one day
	80	1	19	hrs. min.

9. Birthplace Md
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business

FATHER 12. Name William T.Shorb

13. Birthplace Md

MOTHER 14. Maiden name Elizabeth Stambaugh

15. Birthplace Md

16. Informant George E.Myers

Address Detour,Md.

17. (Burial, cremation, or removal. Which?) Burial Date thereof Feb.22,1948 (month) (day) (year)

Cemetery or crematory Keysville

Location Keysville,Md.

18. Funeral director C.O.FUSS & SON

Address Taneytown,Md.

19. 2/21/ 19 48 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 19 1948 at 4 40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 19 1948 to Feb 19 1948 and that I last saw her alive on Feb. 19 1948

Immediate cause of death	DURATION
Respiratory failure	
Due to Bowel Obstruction	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations none Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm H Bradley Jr. M. D. or other

Address Taneytown, Md Date signed 2-19-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01536 - 74

Reg. Diat. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr. 8 mos. 18 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 1 yr. 8 mos. 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 5303 Wesley Avenue, Baltimore 7
(If rural give LOCATION)

2.(a) If veteran, name war No. ✓

3.(a) FULL NAME John Henry Linthicum

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widower

6.(b) Name of husband or wife Ella LAVINIA LINTHICUM 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) December 28, 1872

8. AGE: Years	Months	Days	If less than one day
74	1	26	..... hrs. ..... min.

9. Birthplace Anne Arundel County, Maryland (GALESVILLE)
(Town, county, and state)

10. Usual occupation OFFICE MANAGER

11. Industry or business LEGG & Co. - (RETIRED)

FATHER
12. Name Stephen Lee Linthicum
13. Birthplace Anne Arundel Co., Md.

MOTHER
14. Maiden name Sarah Elizabeth Sherbert
15. Birthplace Anne Arundel Co., Md.

16. Informant WALTER A. LINTHICUM
Address 5303 Wesley Ave

17. BURIAL Date thereof 2/27/48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or ~~crematory~~ CEDAR HILL

Location ANNE ARUNDEL Co.

18. Funeral director WM. J. TICKNER & SONS INC

Address BALTIMORE, MD.

19. Feb 25 1948 A. W. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 24 1948 at 6:18 p M

I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1 1947 to February 24 1948 and that I last saw him alive on February 24 1948

Immediate cause of death	DURATION
Arteriosclerosis	6 yrs.
Due to Terminal Bronchopneumonia (2/6/48 - os.)	
Due to	
Other conditions Inguinal hernia	?
Psychosis with cerebral arterio-sclerosis	6 yrs.

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op. 2/25/48

Autopsy results Pneumonia and pericarditis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury Injured at work?

23. SIGNATURE Martin Gross, M. D.
Martin Gross, M. D. M. D. or other

Address Sykesville, Maryland Date signed 2/25/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

M-45-15M

01537

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

932

Reg. Dist. No. 81

1. PLACE OF DEATH:
County: Carroll
City or town: Union Bridge
(If outside city or town limits, write RURAL, and give nearest town)
How long in above place of death? Deceased
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Union Bridge
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Fannie M. Little

3.(b) Social Security Number: none

4. Sex: Female
5. Color or race: white
6.(a) Single, married, widowed, or divorced: widow
6.(b) Name of husband ~~or wife~~: David E. Little
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Oct. 5 - 1867
8. AGE: Years: 80 Months: 4 Days: 22 If less than one day: hrs. min.
9. Birthplace: Frederick County, Md (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: James Foreman
13. Birthplace: not known
MOTHER 14. Maiden name: Susannah Hiltebridle
15. Birthplace: not known
16. Informant: Elsie M. Kelly
Address: Union Bridge, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/1/48 (month) (day) (year)
Cemetery or crematory: Mountain View Cemetery
Location: Union Bridge, Md
18. Funeral director: W. H. Hartsler & Sons
Address: Union Bridge & New Windsor, Md
19. (Date rec'd by registrar) 1948 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 27 1948, at 11:30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1946 to Feb. 27 1948 and that I last saw her alive on Feb. 26 1948

Immediate cause of death	DURATION
Arteriosclerotic hypertensive C-V disease	1 year
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op.
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: James T. Marsh M.D. M. D. or other
Address: Westminster Md Date signed 2-29-48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01538

1318

Reg. Dist. No. 76

1. PLACE OF DEATH:

County: Carroll

City or town: Rural Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Rural Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No.: RD 6

(If rural, give LOCATION)

2.(a) If veteran, name war: none

3. (a) FULL NAME: Sarah Elizabeth Lockard

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widow

6.(b) Name of husband or wife: Arthur J. Lockard

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): March 10, 1883

8. AGE: Years	Months	Days	If less than one day
64	11	14	..... hrs. ..... min.

9. Birthplace: Carroll County, Md. (Town, county, and state)

10. Usual occupation: none

11. Industry or business:

FATHER — 12. Name: James Baker

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Mary E. Pennington

15. Birthplace: Maryland

16. Informant: Mrs. Charles T. Bitzel

Address: Westminster, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 2/27/48 (month) (day) (year)

Cemetery or crematory: Deer Park Cemetery

Location: Smallwood, Md.

18. Funeral director: J. Francis Reese

Address: Westminster, Md.

19. 2/26 19 48 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 24 19 48 at 2.10p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 44 to 2-24 19 48 and that I last saw h.e alive on 2-23 19 48

Immediate cause of death	DURATION
Hypertrophic Arthritis Osteoma	4 yr
Hypertension (Chr)	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: None Date of

Where did injury occur? None (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: W. C. Jennette M.D. M. D. or other

Address: Westminster Md Date signed 2-26-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01539

Reg. Dist. No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Rural - Eldersburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Carroll

City or town: Rural - Eldersburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: William Foos

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Irene Turner

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 17th, 1890

8. AGE: Years: 57 | Months: 4 | Days: 4 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Balto. Md. (Town, county, and state)

10. Usual occupation: Ship Caler

11. Industry or business

FATHER — 12. Name: Emil J. Foos

FATHER — 13. Birthplace: Germany

MOTHER — 14. Maiden name: Eleanor Beck

MOTHER — 15. Birthplace: Germany

16. Informant: Mrs. Irene Foos

Address: Eldersburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/24/48 (month) (day) (year)

Cemetery or crematory: Parkwood

Location: Parkville, Md.

18. Funeral director: C. J. Fanning & Son

Address: 1938 E. Lafayette Ave.

19. 2/24 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 21st 1948, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 19, 1948, to Feb. 21st 1948, and that I last saw him alive on Feb. 20th 1948

Immediate cause of death	DURATION
Tuberculosis of Lungs	
Due to	
Due to	
Other conditions Hemorrhage Pulmonary (include pregnancy within 3 months of death)	

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: Dr. E. Martin M. D. or other

Address: Randallstown Date signed: 2/27/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

107 01540

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 mo 27 da

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 7 mo 27 da

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Washington

City or town: Keedysville (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war: V

3.(a) FULL NAME: Hattie Elizabeth Lynch

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	Married

6.(b) Name of husband or wife: Howard D Lynch

6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): Aug 7th - 1877

8. AGE: Years: 70 | Months: 6 | Days: 8 | If less than one day: hrs. min.

9. Birthplace: Va (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: at home

FATHER — 12. Name: Benjamin Merryman

FATHER — 13. Birthplace: Va

MOTHER — 14. Maiden name: Ida Merryman

MOTHER — 15. Birthplace: Md

16. Informant: Howard D Lynch

Address: Keedysville, Md.

17. (Burial, cremation, or removal. Which?) Buried Date thereof (month) (day) (year) Feb 20-48

Cemetery or crematory: Boonsboro

Location: Boonsboro Md.

18. Funeral director: R. D. Earnshaw

Address: Keedysville

19. Feb 17 1948 (Date rec'd by registrar) C. Henry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 17 1948 at 8-45 A M

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from June 19 1947 to Feb 17 1948 and that I last saw her alive on Feb 17 1948

Immediate cause of death	DURATION
Bronchio Pneumonia	3 da
Due to: Cerebral Arterio Sclerosis	7 yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. F. Gaston M.D. M. D. or Other

Address: Sykesville md Date signed 2/17/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

13 2

01541

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr. 5 months 16 days

Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Germantown
(If outside city or town limits, write RURAL and give nearest town)

Street No. ✓
(If rural, give LOCATION)

2.(a) If veteran, name war: World War I ✓

3.(a) FULL NAME

James Thomas Noland

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): September 28, 1893

8. AGE: Years	Months	Days	If less than one day
54	4	6	..... hrs. ..... min.

9. Birthplace: Germantown, Maryland
(Town, county, and state)

10. Usual occupation: Farm Laborer

11. Industry or business

FATHER 12. Name: Thomas Noland

FATHER 13. Birthplace: Germantown, Md.

MOTHER 14. Maiden name: Louise Brown

MOTHER 15. Birthplace: Germantown, Md.

16. Informant: Deceased

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/7/48 (month) (day) (year)

Cemetery or crematory: St Rose Cemetery

Location: Cloppers Md -

18. Funeral director: Ernest E Gaither

Address: Gaithersburg Md

19. Feb. 4 1948 (Date rec'd by registrar) Albert R Swanhart Local Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 4 1948 at 10 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 19 1948 to Feb. 4 1948 and that I last saw him alive on February 4 1948

Immediate cause of death	DURATION
Pulmonary Tuberculosis	June 1945
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Reuben Offman, M. D.
M. D. or other

Address: Henryton, Maryland Date signed: 2/4/48

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

01542

CERTIFICATE OF DEATH

Reg. Dist. No. 74

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 11 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 1 month, 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2830 Riggs Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME
MARTIN NORFOLK

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	DIVORCED

6.(b) Name of husband or wife: Lulu Raines
6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): 10/30/99

8. AGE:

Years	Months	Days	If less than one day
48	3	26	... hrs. ... min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Unknown

FATHER
12. Name: John E. Norfolk
13. Birthplace: Calvert County, Maryland

MOTHER
14. Maiden name: Estelle M. Hobbs
15. Birthplace: Frederick County, Maryland

16. Informant: Record, Springfield State Hospital
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal): Date thereof: Feb 28, 1948 (month) (day) (year)
Cemetery or crematory: Cathedral
Location: Baltimore, Md.

18. Funeral director: G. Howard Strong
Address: North Ave. & Hilton St., Balto.

19. Feb 27 1948 (Date rec'd by registrar) Harry Steer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 26 19 48 at 8:40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 15 19 48 to February 26 19 48 and that I last saw him alive on February 26 19 48

Immediate cause of death	DURATION
Pulmonary tuberculosis	2 mos. (known)
Due to:	
Due to:	
Other conditions: Psychosis with CNS Syphilis, tabo-paresis	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Joseph H. Marshall, M.D.
M. D. or other
Address: Sykesville, Maryland Date signed: 2/26/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

107

01543

CERTIFICATE OF DEATH

Reg. Diat. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 years, 26 days
Hospital, institution, or street address where death occurred: Springfield State Hospital
How long in hospital or institution? 13 years, 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Kent
City or town: unknown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Helen Viola Numbers

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 10, 1890

8. AGE: Years	Months	Days	If less than one day
57	9	4	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business

FATHER
12. Name: Fred C. Numbers
13. Birthplace: Maryland

MOTHER
14. Maiden name: Ida Bell Godwin
15. Birthplace: Maryland

16. Informant: Hospital records
Address: Springfield State Hospital

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 17 1948 (month) (day) (year)
Cemetery or crematory Millington
Location Millington Md
18. Funeral director Edward Fellows
Address Millington Md.

19. Feb. 15 1948 (Date rec'd by registrar) Stacy Hess Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 14 1948 at 8.12 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 2, 1942 to February 14 1948 and that I last saw her alive on February 14, 1948

Immediate cause of death	DURATION
Bronchopneumonia	2 days
Due to	
Due to	
Other conditions: Psychoneurosis, mixed type	28 years

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Irene Hohman, M. D.
M. D. or other
Address: Springfield State Hospital Date signed 2-14-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

830~ 01544

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 yrs 1 mo 10 da

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 6 yrs 1 mo 10 da

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Prince George.

City or town: Seat Pleasant (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Olive L Palmer

3.(b) Social Security Number

4. Sex: F

5. Color or race: W

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Melvin Palmer

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): March 8th 1910

8. AGE: Years: 37 Months: 11 Days: 19 If less than one day: ... hrs. ... min.

9. Birthplace: Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: at home

FATHER

12. Name: Frank Dan Spencer

13. Birthplace: Va

MOTHER

14. Maiden name: Sarah E Shriver

15. Birthplace: Va

16. Informant: Melvin Palmer

Address: Seat Pleasant Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 2/48 (month) (day) (year)

Cemetery or crematory: Cedar Hill Maryland

Location: Washington D.C.

18. Funeral director: W. W. Chambers + Co.

Address: Washington D.C.

19. Feb 28 1948 (Date rec'd by registrar) C. Harry Weis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 28th 1948 at 10-30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 17 1948 to Feb 28 1948 and that I last saw h... alive on Feb 28 1948

	DURATION
Immediate cause of death: Cerebral Hemorrhage	1 wk.
Due to:	
Due to: Post Encephalitis	14 yrs
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury: ... Injured at work?

23. SIGNATURE: W. W. Gaston M.D. M. D. or other

Address: Sykesville Md. Date signed: 2/28/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

01545

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:
County: Carroll
City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: EDWARD C. RIGLER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Oct. 2, 1882

8. AGE: Years: 65 | Months: 4 | Days: 2 | If less than one day: ... hrs. ... min.

9. Birthplace: Carroll Co. Maryland (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER
12. Name: George Rigler
13. Birthplace: Maryland

MOTHER
14. Maiden name: Eliza Elgin
15. Birthplace: Maryland

16. Informant: Mrs. Merhl Hahn
Address: Mt. Airy, Md.

17. Burial (Burial, ~~cremation, or removal~~. Which?) Date thereof: 2-6-48 (month) (day) (year)
Cemetery ~~or crematory~~: Bethany
Location: Taylorsville, Carroll Co. Md.

18. Funeral director: C. M. Waltz
Address: Winfield, Md.

19. Feb 6 (Date rec'd by registrar) 19 48 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2-4-48, 19..., at 1; A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19 40, to 2-4- 19 48
and that I last saw h... alive on 2-2- 19 48

	DURATION
Immediate cause of death: Coronary occlusion	Pregnancy - 6 mos.
Due to:	
Due to:	
Other conditions: Epileptic Epilepsie	Life

(Include pregnancy within 3 months of death)

Major findings of operation: NO Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. C. Hone M. D. or other
Address: Westminster Date signed: 2/7/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M


RECEIVED
FEB 9 1948

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01546

57d

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 2 days
Hospital, Institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 1 month, 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: URILLA ROWLAND

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	M

6.(b) Name of husband or wife: Christian Rowland
Deceased 6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Unknown

8. AGE: Years	Months	Days	If less than one day
75	?	?	____ hrs. ____ min.

9. Birthplace: Clear Spring, Maryland (Town, county, and state)
10. Usual occupation: Unknown
11. Industry or business

FATHER
12. Name: George Sprecher
13. Birthplace: Maryland

MOTHER
14. Maiden name: Caroline Zellers
15. Birthplace: Maryland

16. Informant: Record, Springfield State Hospital
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 8, 1948 (month) (day) (year)
Cemetery or crematory: Rose Hill
Location: Hagerstown, Md.
18. Funeral director: A. K. Coffman
Address: Hagerstown, Md.
19. Feb 6 1948 (Date rec'd by registrar) J. Harry Keer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 5, 1948, at 3:20 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 3, 1948 to February 5, 1948 and that I last saw h... alive on February 5, 1948.

Immediate cause of death	DURATION
Generalized arteriosclerosis	
Arteriosclerotic heart disease	
Due to: Myocardial degeneration	
Due to:	
Other conditions: Tumor of left temporal lobe	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____
Autopsy results: As above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury ____ Injured at work?

23. SIGNATURE: Joseph H. Marshall, M.D. M. D. or other
Address: Springfield State Hospital Date signed: 2/6/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M


FEB 9 1948
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01547

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville – Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 mos., 11 days

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 6 mos., 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Baltimore City

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3305 Fenerton Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Elmer Ellsworth Sanders

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Ruth McClelland

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 8, 1895

8. AGE: Years	Months	Days	If less than one day
52	7	10	..... hrs. ..... min.

9. Birthplace: Baltimore City Md. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Continental Can Co.

FATHER — 12. Name: William T. Sanders

13. Birthplace: Baltimore, Md.

MOTHER — 14. Maiden name: Mary Kong

15. Birthplace: Baltimore Md

16. Informant: Hospital records

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 21 1948 (month) (day) (year)

Cemetery or crematory: Baltimore Cem

Location: E North Ave

18. Funeral director: John C Moran

Address: 3000 E Baltimore St

19. Feb 20 1948 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 18, 1948 at 12:10 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 7, 1946 to Feb. 18, 1948 and that I last saw h alive on Feb. 17, 1948

	DURATION
Immediate cause of death: Pulmonary tuberculosis	3 yrs
Due to: Reactive depression	8 mos.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Joseph X. Marshall, M.D. M. D. or other

Address: Springfield State Hospital Date signed 2/18/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01548

83a

CERTIFICATE OF DEATH

Reg. Dist. No. 74

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs 7 mo 26 da

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 2 yrs 7 mo 12 da

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war: /

3. (a) FULL NAME: Laura Jean Lapp.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: [illegible]

6.(c) If alive, give age: [illegible] years

7. Birth date of deceased (mo., day, yr.): Sept 9th - 1881

8. AGE: Years: 66 | Months: 3 | Days: 29 | If less than one day: hrs. min.

9. Birthplace: W Va (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: At home

FATHER

12. Name: Joseph Barick

13. Birthplace: W Va

MOTHER

14. Maiden name: Margaret Dunlevy

15. Birthplace: Scotland

16. Informant: George Lapp. Address: 308 - Maryland Ave Cumberland

17. Cremation (Burial, cremation, or removal. Which?) Date thereof Feb. 11, 1948 (month) (day) (year)

Cemetery or crematory: London Park

Location: Baltimore Md.

18. Funeral director: Harry Heer

Address: Sykesville Md.

19. Feb. 9 1948 (Date rec'd by registrar) Harry Heer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 8th 1948 at 10-15 a M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 12th 1945 to Feb 8th 1948 and that I last saw her alive on Feb 8th 1948

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 wks
Due to Sent. Arteriosclerosis	10 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. H. Gaston M. D. M. D. or other

Address: Sykesville Md. Date signed 2/16/48


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FEB 12 1948
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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

01549

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs 2 mos 5 da

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 14 yrs 2 mos 5 da

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2603 Greenmount Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3. (a) FULL NAME

(Mary Schleigh) Mary Schleigh

3. (b) Social Security Number

None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Aug 24 - 1896

8. AGE:

Years	Months	Days	If less than one day
51	5 mo	25	hrs. min.

9. Birthplace: Md

(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: at home

FATHER 12. Name: John Schleigh

13. Birthplace: Md

MOTHER 14. Maiden name: Catherine Horan

15. Birthplace: Md

16. Informant: Mrs. Irene Angeluer

Address: Sykesville Md

17. (Burial, cremation, or removal. Which?) Burial Date thereof 2/21/48 (month) (day) (year)

Cemetery or crematory: Parkwood Cemetery

Location: Baltimore County Md.

18. Funeral director: George J. Ruth, Inc.

Address: 1735 Harford Avenue

19. 2/18/48 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 18 1948, at 4 a. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec 10 1933 to Feb 18 1948 and that I last saw h. alive on Feb 18 1948

Immediate cause of death	DURATION
Coronary Occlusion	1 da
Due to: Arterio Sclerosis	5 yrs
Due to: Epilepsy	8 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. F. Haston M.D.

M. D. or other

Address: Sykesville Md. Date signed 2/18/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

BC 830

01550

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 yrs 9 mo 22 da

Hospital, institution, or street address (if not at home) Springfield State Hospital

How long in hospital or institution? 7 yrs 9 mo 22 da

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME Carrie Senior

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife Harry Senior

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 29 - 1863

8. AGE: Years 74 | Months 4 | Days 21 | If less than one day ..... hrs. ..... min.

9. Birthplace Md. (Town, county, and state)

10. Usual occupation Artist

11. Industry or business

FATHER 12. Name Christopher Gagley

13. Birthplace Germany

MOTHER 14. Maiden name Carrie Claellemer

15. Birthplace Germany

16. Informant Miss Kate Gagley

Address Hollywood Rd. Balto.

17. Burial (Burial, cremation or removal. Which?) Date thereof Feb. 24 1948 (month) (day) (year)

Cemetery or crematory Loudon Park

Location Baltimore Md.

19. Funeral director C. Harry Heer

Address Sykesville Md.

19. Feb. 21 1948 (Date rec'd by registrar) C. Harry Heer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 20th 1948 at 7:58 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 28th 1940 to Feb 20 1948

and that I last saw h.. alive on ..... 19.....

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 week
Due to Arterio Sclerosis	21 yrs
Other conditions Hypertension	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE J. J. Staston Jr. M.D. or other

Address Sykesville Md. Date signed 2/20/48

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d 01551

Reg. Dist. No. 72

1. PLACE OF DEATH:

County: Carroll

City or town: Rural - Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Few Minutes

Hospital, institution, or street address where death occurred: Silver Run

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Carroll

City or town: Rural - Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No. Nr. Silver Run

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Martha Emma Small

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Maurice C. Small

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): October 29-1908

8. AGE:

Years	Months	Days	If less than one day
39	3	6	..... hrs. ..... min.

9. Birthplace: Littlestown Pa. (Town, county, and state)

10. Usual occupation: School teacher

11. Industry or business: Public School.

FATHER — 12. Name: Paul J. Miller

13. Birthplace: Pa.

MOTHER — 14. Maiden name: Edna Bair

15. Birthplace: Maryland

16. Informant: Willis E. Sleddy

Address: Westminster Md. R. 1

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 7-1948 (month) (day) (year)

Cemetery or crematory: Mt. Carmel Cemetery

Location: Littlestown, PA.

18. Funeral director: J. M. Little & Son

Address: Littlestown, PA. By R. A. Little

19. Feb. 5th. 1948 (Date rec'd by registrar) Calvin E. Bankert Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 4 1948 at 4:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute Cardiac decompensation	
Due to: Chronic Myocarditis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury: ..... Injured at work?

23. SIGNATURE: James T. Marsh, Deputy Medical Examiner M. D. or other

Address: Westminster Md. Date signed 2-4-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01552

CERTIFICATE OF DEATH

Reg. Diat. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 75 W. Green St.
(If rural, give LOCATION)

2.(a) If veteran, name war: none

3.(a) FULL NAME: Myra Olive Smith

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 28, 1861

8. AGE: Years	Months	Days	If less than one day
86	9	23	hrs. min.

9. Birthplace: Rainsburg, Bedford Co., Pa.
(Town, county, and state)

10. Usual occupation: none

11. Industry or business:

FATHER
12. Name: Henry W. Smith
13. Birthplace: Penna.

MOTHER
14. Maiden name: Susannah McCoy
15. Birthplace: Penna.

16. Informant: Dorothy Elderdice
Address: Westminster, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 2/24/48 (month) (day) (year)

Cemetery or crematory: Westminster Cemetery

Location: Westminster, Md.

18. Funeral director: J. Francis Reese

Address: Westminster, Md.

19. 2/21/48 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 20th 1948, at 11 30 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from February 15th 1948, to February 20th 1948 and that I last saw h[illegible] alive on February 20th 1948.

Immediate cause of death	DURATION
Lobar Pneumonia	3 days.
Due to:	
Due to:	
Other conditions: Pernicious Anemia -	2 4 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Walter Bare (M.D.)
M. D. or other

Address: Westminster Md. Date signed: 2/21/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01553

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr. 1 month 13 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or institution? Colored Branch Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Howard Co.
City or town: Elkridge
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Frances Spriggs

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col	Widowed

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Unk. December 25 (?) 1896 (?)

8. AGE	Years	Months	Days	If less than one day
About	50, (?)	1	18	hrs. min.

9. Birthplace: Unknown
(Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business:
FATHER 12. Name: Basil Hawkins
13. Birthplace: Maryland
MOTHER 14. Maiden name: Fellie Brown
15. Birthplace: Maryland
16. Informant: Deceased
Address:
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 2 16 47 (month) (day) (year)
Cemetery or crematory: Mt. Olivet Cemetery
Location: Balto., Md.
18. Funeral director: Mrs. Lottie R. Watkins
Address: 3224 Schroeder St.
19. Feb. 12 19 48 (Date rec'd by registrar) Albert R. Swendsen Local Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 12 19 48, at 6 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 30 19 46 to Feb. 12 19 48 and that I last saw her alive on February 12 19 48
Immediate cause of death: Tuberculosis Of The Hip — DURATION: May 1946
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operation: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

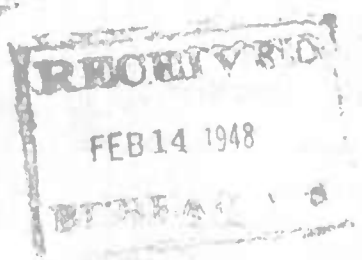
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M. D.
M. D. or other
Address: Henryton, Maryland Date signed: 2/12/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M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FEB 14 1948

01554

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Oakland Mills Sykesville Rt 1
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 yrs

Hospital, institution, or street address where death occurred:
Oakland Rd Oakland Mills Sykesville

How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Carroll

City or town: Oakland Mills Sykesville Rt 1
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Oakland Rd
(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME: Harry Jacob Stern

3.(b) Social Security Number: 214-03-3720

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife: Frances Woodward Stern

6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): Dec 14 1881

8. AGE:

Years	Months	Days	If less than one day
66	2	3	...hrs. ...min.

9. Birthplace: Frizzleburg Carroll Co Md
(Town, county, and state)

10. Usual occupation: Section Mechanic

11. Industry or business: Oakland Woolen Mills

FATHER
12. Name: Nathan Anthony Stern
13. Birthplace: Unknown

MOTHER
14. Maiden name: Anna Sheckels
15. Birthplace: Unknown

16. Informant: Mrs Harry J Stern
Address: Oakland Mills Sykesville Rt 1Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 20 1948 (month) (day) (year)

Cemetery or crematory: Meadow Branch Cemetery
Westminster Md

Location:

18. Funeral director: Wm Berryman & Sons

Address: Reisterstown Md

19. Feb 18 1948 (Date rec'd by registrar) C. Hardy Mc... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 17 1948 at 1 A. M

21. I CERTIFY that death occurred on the date above stated: That I attended deceased from 12-30 1947, to 2-17 1948.

and that I last saw h... alive on 2-16 1948.

	DURATION
Immediate cause of death: Coronary Artery Disease	Approx 6 mo.
Other conditions Due to: Hypertensive C-V. Disease	1 yr.
Due to: Arthritis	5 yrs.
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: None Date of

Where did injury occur? None (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: D. D. Caples, M.D. M. D. or other

Address: 6 Nanwee Rd., Reis. Date signed: 2-19-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01555

136

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 month 25 days

Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch, Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Howard

City or town: Ellicott City
(If outside city or town limits, write RURAL and give nearest town)

Street No. Waterloo Road
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Joseph William Stevenson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col	Married

6.(b) Name of husband or wife: Tora Stevenson

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): October 28, 1894

8. AGE: Years	Months	Days	If less than one day
53	3	14	____ hrs. ____ min.

9. Birthplace: Newbury, S. Carolina
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER
12. Name: William Stevenson
13. Birthplace: Newbury, S. Carolina

MOTHER
14. Maiden name: Sylvia Douglas
15. Birthplace: Newbury, S. Carolina

16. Informant: Deceased

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-14-48 (month) (day) (year)

Cemetery or crematory: Western Star

Location: Catonsville Md

18. Funeral director: F. C. Higinbotham

Address: Ellicott City

19. Feb. 11 (Date rec'd by registrar) 19 48 Local Deputy Registrar

MEDICAL CERTIFICATION A.M.

20. DATE OF DEATH: February 11 19 48, at 1:30 A.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 17 19 47 to Feb. 11 19 48 and that I last saw him alive on February 11 19 48

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Aug. 21 1939

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: Reuben W. Foran, M.D. M. D. or other

Address: Henryton, Maryland Date signed ____

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

932d

01557

Reg. Diat. No. 76

W

1. PLACE OF DEATH:
County Carroll
City or town near Carrollton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 days
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Patapsco
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war none

3.(a) FULL NAME: Elizabeth Taylor

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widow

6.(b) Name of husband or wife Charles E. Taylor
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) November 27, 1874

8. AGE: Years	Months	Days	If less than one day
73	2	18	..... hrs. ..... min.

9. Birthplace Carroll County, Maryland
(Town, county, and state)
10. Usual occupation none
11. Industry or business

FATHER
12. Name John E. Houck
13. Birthplace Maryland

MOTHER
14. Maiden name Martha Miller
15. Birthplace Maryland

16. Informant Mrs. Charles A. Weaver
Address Patapsco, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 2/17/48 (month) (day) (year)
Cemetery or crematory Bethel Church of God
Location Carrollton, Md.

18. Funeral director J. Francis Reese
Address Westminster, Md.

19. 2/16 19 48 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 14, 1948, at 8¼ p. m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..., to Feby 1948
and that I last saw her alive on Feby 14 1948

Immediate cause of death	DURATION
Acute Cardiac Decompensation.	3 days
Due to Chronic Myocarditis	3 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Chas R. Fouty, M.D. (M. D. or other)
Address Westminster Md. Date signed 2-16-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

01556

CERTIFICATE OF DEATH

Reg. Dist. No. 10

1. PLACE OF DEATH:

County Carroll

City or town Taneytown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? lifetime

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Carroll

City or town Taneytown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: John W. Stouffer

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	widower

6.(b) Name of husband or wife: Annie C. Stouffer

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 10, 1851

8. AGE:

Years	Months	Days	If less than one day
96	3	24	..... hrs. ..... min.

9. Birthplace: Md.
(Town, county, and state)

10. Usual occupation: retired day laborer

11. Industry or business

FATHER

12. Name: John Stouffer

13. Birthplace: Md

MOTHER

14. Maiden name: Christiana Wofle

15. Birthplace: Md

16. Informant: Lloyd S. Lambert

Address: Taneytown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 7, 1948. (month) (day) (year)

Cemetery or crematory: Reformed

Location: Taneytown, Md.

18. Funeral director: C. O. FUSS & SON

Address: Taneytown, Md.

19 Feb-5- 1948 Ethel M Mehring
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 3rd. 1948 at 9 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 14th. 1948, to February 3rd. 1948 and that I last saw h.im alive on February 2nd. 1948

Immediate cause of death	DURATION
Cerebral Hemorrhage	21 days.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE O. M. Benner M.D.
M. D. or other

Address Taneytown Maryland Date signed Feb. 4, 1948.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-AT5 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01558

468

CERTIFICATE OF DEATH

Reg. Dist. No. 71

1. PLACE OF DEATH:
County: Carroll
City or town: Linwood
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Rural
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Linwood
(If outside city or town limits, write RURAL and give nearest town)
Street No. Rural
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Lillie Blanche Utz

3.(b) Social Security Number: None

4. Sex: Female
5. Color or race: white
6.(a) Single, married, widowed, or divorced: widowed
6.(b) Name of husband ~~or wife~~: Jonas E Utz
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): April 17 - 1877
8. AGE: Years: 70 | Months: 9 | Days: 16 | If less than one day: ..... hrs. ..... min.
9. Birthplace: Frederick County, Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: At home

FATHER
12. Name: Washington Wetzel
13. Birthplace: Maryland

MOTHER
14. Maiden name: Martha Harris
15. Birthplace: Maryland

16. Informant: Mrs Woodrow Weller
Address: Linwood, Md.
17. Burial (Burial, cremation, or removal. Which?) 2/5/48 Date thereof (month) (day) (year)
Cemetery or crematory: Pipe Creek Cemetery
Location: Uniontown Road
18. Funeral director: H. H. Hafer & Sons
Address: Union Bridge New Windsor, Md.
19. Feb. 4 1948 Margaret R. Englar
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 2 1948, at 6:30 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1947, to Feb 2 1948
and that I last saw h... alive on Feb 2 1948

Immediate cause of death	DURATION
Ca. of Stomach	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury: ..... Injured at work? —

23. SIGNATURE: James T Marsh M. D. or other
Address: Westminster Md Date signed 2-4-48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be sure correct spelling is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr L. K. Hardwood
31 W main St
Westminster

01559

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

13 1a

Reg. Dist. No. 78

1. PLACE OF DEATH:

County Carroll

City or town Westminster - Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 months

Hospital, Institution, or street address where death occurred:
Hale Nursing Home

How long in hospital or Institution? 11 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Taneytown
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mary S. Warner

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Theodore Warner

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 27, 1866

8. AGE: Years	Months	Days	If less than one day
81	7	1	..... hrs. ..... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business Own home

FATHER
12. Name William E. Kesselring
13. Birthplace Maryland

MOTHER
14. Maiden name Susan Baumgardner
15. Birthplace Maryland

16. Informant Richard Rohrbaugh

Address Taneytown, Md.

17. Buried Date thereof March 2, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Jefferson Cemetery

Location Jefferson, Pa.

18. Funeral director C. O. Fuss & Son

Address Taneytown, Md.

19. March 2 1948 Ethel M Mehring Local Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-28- 1948 at 8 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-1- 1947 to 2-28- 1948

and that I last saw h Lr alive on 2-27-48 19.....

Immediate cause of death	DURATION
Cerebral hemorrhage	2 days
Due to Hypertension	
Due to Arteriosclerosis	
Other conditions Chronic nephritis	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Jammy L. Sell M. D. or other

Address Reisterstown Md Date signed 2-28-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01560

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 Months, 5 Days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or institution? Colored Branch, Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Dorchester
City or town: Hurlock
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: JAMES AUGUSTUS WASHINGTON

3.(b) Social Security Number: 218-01-4502

4. Sex: Male
5. Color or race: Colored
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Martina Washington
6.(c) If alive, give age: 42 years
7. Birth date of deceased (mo., day, yr.): October 15, 1900
8. AGE: Years: 47 Months: 4 Days: 5 If less than one day: hrs. min.
9. Birthplace: Finchville, Maryland
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business
FATHER 12. Name: Adam Washington
13. Birthplace: Denton, Maryland
MOTHER 14. Maiden name: Laura James
15. Birthplace: Denton, Maryland
16. Informant: Deceased
Address
17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-23-48 (month) (day) (year)
Cemetery or crematory: Spunners Run Cem.
Location: Dorchester Co., Md.
18. Funeral director: J. J. Frampton & Son
Address: Federalsburg, Md.
19. Feb. 20, 1948 (Date rec'd by registrar) Albert A. Swanberg Local Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 20, 1948, at 5:A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 15, 1948 to Feb. 20, 1948 and that I last saw him alive on February 20, 1948

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Dec. 1944

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben W. Brown, M. D.
M. D. or other
Address: Henryton, Md. Date signed: 2-20-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

01561

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

183

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Limit - Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 yrs.

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 7 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Carroll

City or town: Limit - Sykesville

(If outside city or town limits, write RURAL and give nearest town)

Street No. Springfield State Hospital

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Clarence Wilhelm

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 13-1920

8. AGE:

Years	Months	Days	If less than one day
27	2	24	hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Bowling alley laborer

11. Industry or business:

FATHER — 12. Name: Edmund Wilhelm

13. Birthplace: Md

MOTHER — 14. Maiden name: Vilda Sherman

15. Birthplace: Maryland

16. Informant: Hospital Records - Springfield State Hosp.

Address: Sykesville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 9 1948 (month) (day) (year)

Cemetery or crematory: Mt. Carmel

Location: Hartland Md.

18. Funeral director: Chenoweth & Donovan.

Address: 3615-17 Chestnut Ave.

19. Feb 7 1948 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 7, 1948, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h... alive on ..... 19.....

Immediate cause of death	DURATION
Drowning	
Due to: Epileptic Convulsion.	
Due to: Epilepsy	10 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: Feb 6. 48

Where did injury occur? Sykesville (City or town) Carroll (County) Md (State)

Injured at home, farm, industry, public place (where?): S. S. Hospital

Means of injury: Drowned in bath tub Injured at work? no

23. SIGNATURE: James T. Marsh Jr. State Medical Examiner M. D. or other

Address: Westminster Md Date signed: Feb 6-1948

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d 01562

CERTIFICATE OF DEATH

Reg. Dist. No. 8c

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:
County Carroll Co.
City or town Rural near New Windsor (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? About 2 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Carroll
City or town Rural near New Windsor (If outside city or town limits, write RURAL and give nearest town)
Street No. (Wakefield Valley) (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Charles Milton Yingling
3. (b) Social Security Number None

4. Sex M
5. Color or race W.
6.(a) Single, married, widowed, or divorced widowed
6.(b) Name of husband or wife Mary A. Yingling
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) March 22, 1865
8. AGE: Years 82 Months 10 Days 25 If less than one day ... hrs. ... min.
9. Birthplace Westminster, Carroll Co. Md. (Town, county, and state)
10. Usual occupation laborer
11. Industry or business

FATHER
12. Name Noah Yingling
13. Birthplace Carroll Co. Md.

MOTHER
14. Maiden name Rebecca Myers
15. Birthplace Carroll Co. Md.

16. Informant Mrs. Daisy A. Yingling
Address Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb/20/48 (month) (day) (year)
Cemetery or crematory Westminster Cemetery
Location Westminster, Md.

18. Funeral director J. E. Myers Jr.
Address Westminster Md.

19. Feb 20 (Date rec'd by registrar) 19 ... Oscar D. Bucher Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 17 1948, at 8:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1936 to February 17 1948 and that I last saw him alive on February 15 1948

	DURATION
Immediate cause of death Coronary occlusion	2 da.
Due to Arterio Sclerosis (General) Myocardial	
Due to Degeneration	
Other conditions Gall Bladder disease (Chronic) (Include pregnancy within 3 months of death)	4 yrs.

Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE W. Glenn Speicher M. D. or other
Address Westminster Md Date signed 2/17/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01563

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 yrs., 3 mons., 26 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or institution? Colored Branch

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 650 Bradley Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: JAMES YOUNG, JR.

3.(b) Social Security Number: 219-01-7903

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 2, 1901

8. AGE: Years	Months	Days	If less than one day
46	11	24	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER
12. Name: James Young
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden name: Emma Nelson
15. Birthplace: Baltimore, Maryland

16. Informant: Deceased
Address:

17. Burial, cremation, or removal. Which? Burial Date thereof 3/1/48 (month) (day) (year)
Cemetery or crematory: Arbutus Memorial
Location: Cear Hill
18. Funeral director: F. Halstead
Address: 918 Drumhill Ave

19. Feb. 26, 1948 (Date rec'd by registrar) Albert R. Swank Local Deputy Registrar

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH: February 26, 1948 at 6:40 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 30, 1941 to Feb. 26, 1948 and that I last saw him alive on February 26, 1948

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Sept. 1938

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M. D. (M. D. or other)
Address: Henryton, Md. Date signed: 2-26-48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

95C

Reg. Diat. No. 75 A1564

1. PLACE OF DEATH:

County: Carroll

City or town: Alesia
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Alesia
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Ralph W Young

3.(b) Social Security Number 218-24-9310

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife: Janie Young

6.(c) If alive, give age: 38 years

7. Birth date of deceased (mo., day, yr.): July 18 - 1900

8. AGE:

Years	Months	Days	If less than one day
47	6	24	...hrs. ...min.

9. Birthplace: North Carolina
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Canning Factory

FATHER
12. Name: Unknown

13. Birthplace

MOTHER
14. Maiden name: Ada Gouge

15. Birthplace: North Carolina

16. Informant: Mrs Janie Young

Address: Alesia Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Feb 14/48 (month) (day) (year)

Cemetery or crematory: Alesia Free Methodist

Location: Carroll Co Md

18. Funeral director: Edw A Tipton

Address: Hampstead Md

19. Feb 14th 1948 M/o. M.P.S. Denver
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 12 1948 at 7:00 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 1938 to Feb. 12 1948 and that I last saw h... alive on Feb. 10 1948

Immediate cause of death	DURATION
Congestive heart failure	3 weeks
Due to: Rheumatic Heart disease	10 years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Maurice C. Porterfield M. D. or other

Address: Hampstead, Md Date signed: 2-12-48

W

I

T

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M